University Health Center Providers' Beliefs About Discussing and Recommending Sexual Health Prevention to Women College Students

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Abstract

Sexual health concerns such as sexually transmitted infections and unintended pregnancy remain substantial health problems faced by young adults, especially college women. University healthcare providers may be instrumental in increasing female patients' involvement in preventative sexual health behaviors, however little research has examined this issue. In-depth interviews were conducted with women's clinic providers at a university health center using the Reasoned Action Approach (RAA) to better understand providers' beliefs about discussing and recommending sexual health prevention to their patients. Providers felt comfortable and confident discussing and recommending various sexual health prevention behaviors and stated that a health history questionnaire is a useful tool to guide this process. However, they stated time restraints greatly limit their ability to adequately address preventative health practices when more pressing issues needed to be addressed. College health professionals should include providers as a component of prevention interventions and utilize providers as a mechanism to increase preventative health behaviors.

Introduction

Sexual health concerns (i.e., sexually transmitted infections (STI), Human Immuno-deficiency Virus (HIV) and unintended pregnancy) remain pervasive health issues, particularly among teenagers and young adults. In the US, there are approximately 19 million new cases of STIs (excluding HIV) each year with about two-thirds of new cases occurring among individuals under the age of 25 years (Centers for Disease Control and Prevention (CDC), 2011a). Additionally, approximately 1.2 million people in the US are HIV positive with 26% of new infections occurring among individuals under the age of 25 and about 21% of HIV positive individuals unaware of their positive status. Although rates of unintended pregnancy have been on the decline in recent years (Guttmacher Institute, 2011), approximately half of all pregnancies in the US are unintentional, unplanned, or mistimed (Finer & Henshaw, 2006; Finer & Zolna, 2011; Mosher, Jones, & Abma, 2012). The US remains among the highest of all industrialized countries regarding rates of unintended pregnancies (CDC, 2011b).

Despite prevention initiatives, STIs and HIV remain a significant source of potentially preventable morbidity. In addition, women who experience an unintended pregnancy often drop out of school or delay graduating high school or college due to the pregnancy (Styles, 2011). Nationally, annual costs associated with unintended pregnancy exceed 11 million dollars annually (Sonfield, Kost, Gold & Finer, 2011).

Public health practitioners and educators have put forth tremendous effort to address these sexual health concerns in order to prevent and control the spread of STIs and HIV, as well as to prevent unintended pregnancies, especially at the university level. One mechanism to address sexual health concerns has been to engage healthcare providers in health education and promotion of prevention with their patients, especially university healthcare providers as they may be able to work closely with health promotion and health education departments in university health center clinics. The American Medical Association (AMA) provides recommendations for healthcare providers regarding prevention and health promotion initiatives in the Guidelines for Adolescent Preventative Services (GAPS; AMA, 1997). For example, the AMA recommends that healthcare providers screen all adolescent patients for sexual activity including sexual behaviors that might result in unintended pregnancy and STI/HIV contraction. They recommend that sexually active adolescents be asked specific questions about their sexual behavior such as: (1) motivation for condoms and contraceptive methods use, (2) number of sexual partners, (3) history of exchanging sex for money, (4) past screenings for STIs including a pap smear for female adolescents, and (5) past HIV screenings. Providers should also counsel adolescents at risk for pregnancy and STI/HIV transmission about how to reduce their risk (AMA, 1997; Workowski & Berman, 2010). Although GAPS dates back to 1997, these guidelines are still the recommended standard of practice for adolescent preventative health services according to the AMA.

The United States Preventive Services Task Force (USPSTF; USPSTF, 2008; Meyers, et al., 2008) recommends that healthcare providers engage in some form of behavioral counseling with their patients with regard to STI/HIV prevention and the CDC (2011a) outlines a list of prevention strategies in their clinical guidelines for healthcare providers. The guidelines encourage healthcare providers to educate patients on using condoms, limiting number of sexual partners, and about using highly effective (hormonal) birth control methods (Workowski & Berman, 2010).

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Although groups like the AMA, USPSTF, and CDC recommend healthcare providers follow certain guidelines to increase prevention efforts, such guidelines do not ensure compliance. For example, STI screenings are below recommended rates. Many providers fail to take a complete sexual history (Merrill, Faux, & Thornby, 1990; Verhoeven et al., 2003) and few providers educate patients about how to prevent STI/HIV transmission (Matthew & Fletcher, 2001). Providers reported feeling uncomfortable discussing matters related to sexual behavior with their patients (Hinchliff, Gott, & Galena, 2004; Meystre-Agustoni, Jennin, & Dubois-Arber, 2006; Temple-Smith, Mulvey, & Keogh, 1999; Tomlinson, 1998). They report receiving inadequate training, feeling embarrassed, and being afraid to offend patients as common reasons for not taking sexual health histories (Meystre-Agustoni et al., 2006; Verhoeven et al., 2003; Temple-Smith, Mulvey, & Keogh, 1999; Temple-Smith, Hammond, Pyett, & Presswell, 1996; Merrill, Faux, & Thornby, 1990).

In summary, although there are a number of guidelines about what providers should do, the limited, available literature demonstrates that providers often do not meet the recommended guidelines. What is less clear is why they are not meeting these guidelines. Given this gap, it is important to study healthcare providers' perspective on promoting preventive sexual health behaviors. University healthcare providers are a specific subset of healthcare providers who uniquely interact with primarily college students. Such providers interact almost exclusively with individuals in late adolescence/early adulthood, where risks of contracting STIs and experiencing unintended pregnancy are high. As such, the goal of this study was to understand university providers' perspective on initiating conversations with patients with respect to sexual health and promoting patients' engagement in actions to protect their sexual health.

Methods

Overview

The current study utilized a combination of the Reasoned Action Approach (RAA; Fishbein & Azjen, 2010) and Critical Qualitative Methodology (Carspecken, 1996) to assess university healthcare providers initiating conversations with their college women patients to address their sexual health. The RAA was used as a model to formulate interview questions for healthcare providers. The RAA focuses on the importance of understanding the perceptions of individuals and examines the influence of individuals' attitudes (attitude towards the act), perceived normative pressure (perceived norm), and self-efficacy (perceived behavioral control) on the performance of the behavior. Carspecken's (1996) Critical Qualitative Methodology, derived from Habermas' Communicative Action Theory (Habermas, 1989), in combination with Hesse-Biber and Leavy's (2007) qualitative interview and analysis methodology, influenced the interview protocol (a dialogic protocol) as well as the data analysis (inductive content analysis). Carspecken's (1996) methodological approach requires that participant autonomy be maintained (the investigators viewed the research process as a *participatory effort* rather than the researcher conducting a study on a subject), and an egalitarian relationship between the participant and researcher sought. These interview techniques were utilized in order to put the participant at ease, thus decreasing the likelihood of response bias and increasing the validity of the participants' responses.

Participants and Study Procedure

Women's healthcare providers who were currently employed at the University Health Center at a large Midwest university were invited to participate in the study. Participants were recruited at a monthly meeting that all women's healthcare providers (i.e., medical doctors, nurse practitioners, physicians' assistants, nurses) were required to attend. We asked providers interested in participating to e-mail the primary investigator to set up a time to conduct the interview. All ten healthcare providers who examine women patients at the University Health Center agreed to participate in the one-on-one interviews. Participation was voluntary; however, providers received a $50.00 gift card as incentive for participation. The study protocol was approved by the university's Institutional Review Board.

Interview Protocol

The interview protocol was loosely based on the constructs of the RAA. The RAA was utilized to identify underlying determinants that influence the behavior of healthcare providers initiating conversations with patients addressing their sexual health and patients' engagement in preventative sexual health behavior. The RAA is the most recent formulation of the Theory of Reasoned Action, the Theory of Planned Behavior, and the Integrated Model (Fishbein & Ajzen, 2010). It has been used to understand a variety of health behaviors (Albarracín, Johnson, Fishbein & Muellerleile, 2001; Hagger, Chatzisarantis & Biddle, 2010), proposing that intention is the immediate determinant of behavior and that attitude, perceived norm, and self-efficacy combine as global components to influence intention. According to the RAA, there is a belief structure underlying the three global components (i.e., beliefs about perceived consequences, perceived social referents, and perceived circumstances) that influence behavioral decisions. However, only the salient or top-of-the mind beliefs are potential belief determinants. The interview protocol was designed in order to identify these top-of-the mind beliefs. During the interviews, based on the RAA guidelines, participants were asked to indicate:

1. What took place during a typical interaction with their patients.
2. How comfortable they felt initiating conversations addressing patients' sexual health and patients' engagement in preventative sexual health behaviors.
3. Salient consequences: advantages and disadvantages to initiating conversations addressing patients' sexual health and patients' engagement in preventative sexual health behaviors.
4. Salient circumstances: facilitators and barriers to initiating conversations addressing patients' sexual health and patients' engagement in preventative sexual health behaviors.

Finally, we asked providers to describe their perceptions of patients' salient referents; however this data will not be presented in this paper.

Because the specific interview protocol was dialogic and based on Carspecken's (1996) methodology, specific interview questions were intended to be largely open-ended, which resulted in leeway for continued follow up questioning during the interview process (See Figure 1 for example lead-off interview questions). The interviewer and each of the participants discussed what was meant by preventative sexual health behaviors/issues and sexual health prevention. These terms were used to describe healthcare providers' promotion of behaviors such as: (1) getting tested for STIs, (2) getting the HPV vaccine, and (3) utilizing contraceptives including condoms. The interview questions prompted follow-up discussion such that participants provided responses that addressed the research goals.

Analyses

Interview data were transcribed verbatim and analyzed using critical qualitative analytical techniques such as meaning field analysis and reconstructive validity horizon analysis (Carspecken, 1996). When conducting meaning field analysis, the researcher(s) assess all potential meanings of the statements made by participants. When conducting reconstructive validity horizon analysis, the researcher(s) clarify impressions of meanings from participants' statements (and from the meaning field analysis) in order to determine what the researcher(s) might be missing, what biases might be in play, and what cultural forms are necessary to understand through future analysis (Carspecken, 1996). These analytic techniques helped inform the coding procedures. Specifically, a multi-layered coding scheme was developed to analyze data emically (i.e., coding categories that emerge from the data; Hess-Biber & Leavy, 2007).

Data were coded by the first and second author. First, we reviewed different subsets of the data to generate a family of codes based on emerging themes. Analytic techniques described above (Carspecken, 1996) were utilized to inform the code generation. Each author generated her/his own list, then compared lists, looking for similarities, overlaps, and differences. We then agreed on a final coding scheme by combining the two lists. The developed codes addressed the presumed meaning underlying the participants' statements (Hesse-Biber & Leavy, 2007). In other words, codes were identified as a series of common themes through which providers' responses could be reasonably interpreted. Data analysis provided insight into participants' subjective experiences, which in turn helped us conceptualize the providers' world view as it relates to health-seeking behaviors and what role they could play in increasing patients engagement in preventative health behaviors.

Results

Participant Characteristics

Participants included medical doctors (n = 3), nurse practitioners (n = 6), and a physician's assistant (n = 1) at a large Midwestern university health center. These practitioners indicated working primarily in general health care (n = 3), primarily in women's health care (n = 4), or in both general and women's health care (n = 3). Seven participants labeled themselves as mid-level providers, two as supervising physicians, and one as the medical director. All participants were women, white and between the ages of 34 and 62 (M = 53.6, SD = 7.65). The study body at the university of data collection is primarily white, similar to the demographic make-up of the state.

Provider and Patient Comfort

We asked participants to describe a typical interaction they had with their patients. In this conversation, participants were also asked if they spoke with patients about sexual health prevention in general. In their responses, most providers mentioned feeling generally comfortable talking to their patients about sexual health topics and specifically comfortable engaging in conversations about sexual health promotion and prevention techniques. In fact, many providers viewed sexual health promotion similar to other types of health promoting behaviors as demonstrated by the quote below: *"I feel really comfortable talking about sexual health. I usually smile, put on a friendly face to show my comfort. I approach it like other medical issues. Why is sexual health any different, than say heart health?"*

Other providers mentioned engaging in behaviors such as smiling and trying to look "as friendly as possible" in order to put patients at ease. Providers indicated that their demeanor was instrumental in getting patients to open up and tell them

1. As you might know, many college students are sexually active. During your interactions with patients, do you address the topic of sexual health? How do you initiate those dialogues?
2. Describe a typical conversation with a patient in which you address preventative sexual health issues?
3. What are some of the advantages/disadvantages of addressing sexual health prevention with your patients?
4. What are some of the factors that make it easier/more difficult to address sexual health prevention with your patients?

Figure 1. Example Lead-off Questions for Interview

information. All of the participants indicated that when they first met with a patient they introduced themselves, usually shook the hand of the patient, smiled, made eye contact as much as possible and tried to give off a cheery disposition. The providers indicated that following these procedures often resulted in patients not only feeling more at ease with the specific provider, but with the whole process of going to the doctor. Providers also mentioned that physical contact with patients was instrumental in increasing patient comfort as exemplified by the following: *"The initial contact, that physical contact with the patient helps instead of not making contact beforehand. I think that actually reaching out and physically touching them right off the bat really makes a difference."*

Although most providers reported being comfortable discussing sexual health, one provider reported some discomfort. She indicated feeling uncomfortable discussing sexual health topics and in particular promoting safe sex behaviors. This provider implied that perhaps young, unmarried people should not be engaging in sexual activity and that her engagement in sexual health promoting behaviors (i.e., counseling patients to wear condoms to protect against STIs/HIV and unintended pregnancy) might appear like she is promoting sexual activity among her patients. This provider stated:

Participant (P): *I think it is important to promote sexual health, but there is something about telling young people to wear condoms that makes me feel a little uncomfortable*.

Interviewer (I): *What makes you feel uncomfortable about it?*

P: *It seems like I am condoning the behavior, or more than that, perhaps that I am promoting the behavior. I know that is not true, I know that me giving out condoms or telling patients to wear condoms will not cause them to have sex, but I just feel like it is telling them it is okay, when I am not sure that it is.*

Other providers mentioned that they perceived some patients felt uncomfortable with the provider talking about sexual health promotion when someone else was present in the room during the exam (i.e., parent). These issues will be discussed in the context of salient circumstances as barriers to discussing sexual health promotion.

Finally, it is important to note that several providers stated that their comfort level in addressing sexual health promotion has increased with experience. For example, one participant stated: *"I think the longer I do this, the more comfortable I am with bringing up these topics and talking to patients about sexuality."* Another participant stated: *'I feel comfortable now talking to patients about these health issues, but I think some of that has come with practice and time. The more experience I have gotten under my belt, I think the more comfortable I have gotten."*

Health Promotion and Prevention

We specifically asked these university health center providers if they currently discuss sexual health promotion with their patients. All of the healthcare providers mentioned promoting sexual health. A wide variety of sexual health promotion techniques were used, including: counseling patients about how to prevent STI/HIV transmission and/or unintended pregnancy (i.e., encouraging patients to use latex condoms and/or highly effective contraceptive methods and reducing their number of sexual partners), encouraging patients to get the HPV vaccine, encouraging women patients to have a pap test, testing patients for STIs/HIV, referring patients to sexual health educators for questions about prevention, referring patients to literature about STI/HIV prevention, and informing patients about the emergency contraceptive pill. Many providers indicated that they thought prevention was a part of their job and they tried to engage in sexual health promotion whenever possible as exemplified by the following quote:

"I know we [healthcare providers] are on the care end of the health spectrum, but I see my job as not only providing treatment, but also providing information and advice so that patients don't have to see me again…at least not for something they could prevent."

Salient Consequences: Advantages and Disadvantages

Providers were asked to indicate positive and negative outcomes or consequences associated with addressing sexual health promotion and prevention with their patients. As can be seen in Table 1, providers listed many advantages to promoting sexual health behaviors among their patients. Positive outcomes included physical health outcomes (e.g., protecting against infection or disease, decreasing the need for treatment) but also emotional outcomes (e.g., reducing patients emotional stress). The most commonly indicated response was that there were no disadvantages to addressing sexual health promotion with patients. Providers generally indicated that they were hard pressed to come up with negative consequences in addressing sexual health promotion with their patients. When we probed further, providers stated that talking about sexual health issues might make their patients uncomfortable. The providers also noted that talking about these issues might result in other providers feeling uncomfortable, although all but one stated that they were comfortable.

Salient Circumstances: Facilitators and Barriers

As shown in Table 2, a number of facilitating and hindering circumstances were elicited when providers were asked what made discussing sexual health easy and difficult. Some of the circumstances involved aspects of the patients (e.g., patient feeling embarrassed; patient feeling invincible when it comes to HIV). Other circumstances involved characteristics of the providers (e.g., having experience; being open and willing to answer questions). And some circumstances involved the larger clinic (e.g., having time) and sociocultural environment (e.g., sex being taboo). Providers mentioned a number of specific strategies that they use to make it easier to address sexual health promotion with patients. For example, providers reported asking patients to fill out a sexual health history questionnaire while they sit in the waiting room. Providers noted that being able to utilize the sexual health history questionnaire as a means to start conversation was an important factor that made it easier to discuss sexual health promotion. One participant stated *"The health history questionnaire is really helpful because you can use patients'*

Table 1

Providers' beliefs about the salient consequences of initiating conversations with patients

Advantages	**Disadvantages**
Protect against STI/HIV, cervical cancer and unintended pregnancy	Patients' discomfort
Decrease procedures/need for treatment	Providers' discomfort
Reduce emotional distress	Lack of training
Help patients better understand their health	
Increase patient interest in STI/HIV and pregnancy prevention	
Prevention decreases healthcare costs	
Prevention is always better than treatment	

Table 2

Providers' beliefs about the salient circumstances regarding initiating conversations with patients

Facilitators	**Barriers**
Patients being comfortable talking about sexuality	Patients feeling embarrassed, uncomfortable, worried or afraid
Creating a comfortable environment	Sex being a taboo topic
Having enough time	Lack of time in general and lack of time due to more important treatment related needs
Inform patients that discussions are confidential	Patients not entirely honest/reluctant to share information with providers either intentionally or unintentionally
Being open and willing to answer questions	Patient may be misinformed or uneducated about sexual health topics
Setting goals to address sexual health promotion	Having someone else in the room during the patient exam
Feeling confident in ability to provide sexual health education/ counseling	Patients having other healthcare providers who give different advice
Engaging in health promotion while performing other procedures (i.e., pap smear)	Patients feeling invincible against STI/HIV
Utilizing health history questionnaire	Providers perceived patients' religious beliefs
Having experience and being adequately trained to provide health counseling	

responses to initiate dialogue" and another participant stated *"The health history questionnaire kind of acts like a crutch. It prompts me to talk about things like the HPV vaccine and also helps break the ice when I first start talking to a patient about her behaviors."*

From the perspective of the providers, an important barrier to discussing sexual health was patients' discomforts and intentional (dishonesty) or unintentional (forgetfulness) relay of misinformation. Providers stated that when they suspected a patient was uncomfortable or not being entirely honest, they felt inclined to back off asking the patient for more information. However, providers mentioned several strategies to attempt to overcome patients' discomfort, such as creating a comfortable environment by engaging in behaviors that indicated that they were open and willing to talk about sexual health. They also indicated that answering questions helped put patients more at ease. One provider stated:

"I try to do a lot of things that indicate I am open to talking—like maintaining eye contact, shaking my head to indicate I am listening, not showing a reaction when patients make statements about their sex life, and making non-judgmental comments."

Discussion

Findings from this brief report provide preliminary data examining why some university health center providers may not meet the recommended guidelines regarding the discussion of sexual health and the promotion of preventive sexual health discussed previously. Based on the findings from this brief report, we suggest ways to encourage university healthcare providers to initiate discussion of sexual health and furthermore, outline how this discussion might lead to the improved practice of preventive behaviors on the part of the college student patients they see and call for additional research with a more diverse sample of healthcare providers to further examine this issue.

University health center healthcare providers indicated feeling comfortable talking about sexual health issues with their patients. They strongly endorse having an open dialogue and attempting to achieve a forum for open discussion by remaining open-minded and demonstrating a positive attitude towards sexual health issues with their patients. The findings demonstrate that these healthcare providers have high self-efficacy when it comes to initiating discussions. That is, they mentioned feeling confident and comfortable talking to their patients about sexual health prevention. One provider mentioned feeling uncomfortable talking about preventative sexual health behaviors with her patients (i.e., the HPV vaccine, using condoms) because she indicated it would be analogous to promoting having sex or at least condoning the sexual activity, which she implied she morally did not agree with. However, out of the ten providers, she was the only one who demonstrated this opinion.

With regard to the salient consequences of discussing sexual health, the providers mentioned several advantages to promoting sexual health behaviors that would protect patients from disease and from unintended pregnancy; this is especially important given the high rates of STIs and unintended pregnancy experienced by young adults in the US (CDC, 2011a; Guttmacher Institute, 2011). However, advantages went beyond physical aspects of sexual health. Talking about sexual health and prevention was viewed as a mechanism to reduce the patients' stress level. Given that college students suffer from high rates of stress and suicide (Hass Mendin & Mann, 2003), anything that can be done to reduce the stress level of college students might likely be beneficial to their overall health and, thus, represents an additional advantage to talking about these issues. Providers believed that encouraging preventive sexual health practices would have the benefit of reducing costs for students specifically, as well as, societal healthcare costs in general. That is, these providers believed that recommending sexual health prevention behaviors would be more cost effective compared to paying for treatment of disease or the cost of experiencing an unintended pregnancy. Finally, providers indicated discussing sexual health prevention supported a culture of sexual openness and could potentially reduce taboos surrounding sexuality. Providers believed that if they were able to comfortably talk with patients about sexuality, patients might in turn feel more comfortable talking about these topics with partners or others.

When asked about barriers to discussing preventive sexual health behaviors with patients, providers mentioned aspects of the patients' behaviors and beliefs as the most prominent barriers to making appropriate sexual health recommendations to patients. For example, one of the most salient barriers to adequately addressing preventative sexual health with their patients was providers' perceptions that their patients were not always honest with them either intentionally (i.e., patients might be dishonest regarding the behaviors they are engaging because they are embarrassed) or unintentionally (i.e., patients might be forgetful). Providers indicated that such factors associated within the patient hindered providers' ability to provide accurate recommendations to patients regarding steps they could take to improve their sexual health. Lastly, providers mentioned aspects of the social environment such as sex being a taboo topic as a barrier. However, providers also indicated that they believed their engagement in dialogues with patients about sexuality could potential increase general comfort in talking about sex, thus minimizing the extent to which patients might view sex as taboo. Although the findings from the current study apply specifically to university healthcare providers, some of the findings may apply more broadly to general healthcare providers.

Implications for Interventions

Current data provide some important insight addressing the gap between provider guidelines (USPSTF, 2008; Meyers, et al., 2008; CDC, 2011) and providers' actual behaviors with regard to initiating conversations about sexual health among a sample of university healthcare providers. Previous research indicates that healthcare providers are salient referents when it comes to college students making decisions about preventative sexual health behaviors such as vaccination (Geshnizjani, Jozkowski & Middlestadt, 2012). As such, university healthcare providers potentially play an important role in influencing college students' practice of sexually healthful behavior. The following section outlines recommendations for provider interventions that would encourage them to initiate discussions with their patients about sexual health that might ultimately

facilitate the practice of preventive behaviors by the women they serve.

Current findings suggest that when providers have high self-efficacy, they feel comfortable talking to patients about sexual health issues and recommending preventative sexual health tactics. Therefore, interventions targeting healthcare providers could focus on increasing providers' self-efficacy in order to help those that might not be as comfortable feel confident talking to patients about sexual health issues and recommending preventative sexual health behaviors. Self-efficacy has been widely used in theory-based interventions with a wide variety of behaviors (Geshnizjani, Torabi, & Jozkowski, 2011). Providers being comfortable and confident might be of particular importance to clinicians who provide healthcare to college students as college students might feel shy, embarrassed, or uncomfortable talking about sexuality (Bogle, 2008). Having a salient referent who can confidently and comfortably talk to them about sexual health might increase their intention to take actions to protect their sexual health, including talking to potential partners.

Public health interventions could also focus on providing skills-based training for healthcare providers to aid in initiating and engaging in conversations with patients about preventive sexual health behaviors. Current findings indicated that providers perceived having a non-judgmental attitude as a facilitator to increasing patients' engagement in sexual health prevention. Previous research indicates that providers might not be adequately trained with regard to talking to patients about sexuality and promotion of preventative sexual health behaviors (Verhoeven, 2003). Therefore, skills-based training aimed at helping providers remain objective and non-judgmental in their dialogues with patients might be beneficial in increasing patients' involvement in prevention related behaviors.

Current findings also indicated that healthcare providers perceived having more experience as a facilitator in terms of talking to patients about sexual health. Perhaps structural interventions in which clinics pair experienced providers with new providers might help the less experienced providers learn how to approach talking to patients about sexuality. Given that providers mentioned patients' discomfort and lack of honesty (intentional and unintentional) as potential barriers to discussing preventive sexual health, perhaps interventions could focus on skills-based training to also help providers increase patients' comfort level during visits. Some of the strategies that could be taught include smiling or shaking hands with the patient. Additionally, setting up a clinical policy to complete a questionnaire that helps jog patients' memories might increase the accuracy of the information they provide. Alternatively, use of strategies that are aimed at raising awareness about the high prevalence of STIs (i.e., providers discussing statistics with patients to highlight how common STI diagnoses are, especially among young people) might help encourage patients to feel less embarrassed or ashamed and, in turn, increase their likelihood of being honest about their own behavior.

Lastly, according to the descriptive norms construct in the RAA, providers are influenced by the behaviors of their peer healthcare providers. Therefore, through increasing the comfort level of some healthcare providers, a normative environment of comfort can be created, thus, influencing other providers who might feel less comfortable. This in turn could increase dialogues between patients and providers regarding preventative sexual health as well as potentially increase dialogues outside of the context of the healthcare setting.

Limitations

Although this article provides important exploratory data addressing the gap between recommendations for healthcare providers regarding sexual health promotion and what providers actually do, there are important study limitations to note. First, all healthcare providers were recruited from one university setting. Therefore, the results might not reflect the beliefs and behaviors of all university healthcare providers or of providers in other settings. Given that the healthcare providers included in the current sample are consistently exposed to young people, they might be more likely to feel comfortable talking about sexuality compared to other clinicians in different settings because it is the general expectation that college students are sexually active (Bogle, 2008). Additionally, all of the university healthcare providers in the current sample identified as white women resulting in a fairly homogeneous sample. It may be the case that women providers are more comfortable discussing sexual health issues with young women as opposed to male providers or that race/ethnicity may be playing some role in terms of increasing or decreasing comfort levels of providers. Thus, future research may benefit from including a more diverse sample of healthcare providers in terms of both gender and race/ethnicity. Although the critical interviewing techniques were designed to minimize bias, the use of face-to-face interviews might have led to a social desirability bias. Lastly, given the exploratory nature of the current study, the sample size is relatively small. Future qualitative research may specifically probe for other factors that could potentially influence healthcare provider's comfort in promoting healthy sexuality. For example, other possible factors such as geographical location, the university/academic system, or factors associated with the student body may influence healthcare providers. Additional quantitative research with larger and more diverse samples of healthcare providers who serve different populations and with an instrument with close-ended items based on the results of this qualitative article would help to verify the findings suggested here and examine how well they extend to different providers and settings. In addition, intervention research might be conducted to test some of the strategies mentioned by these providers.

Conclusions

In summary, this study was an exploratory, qualitative, RAA-based approach to gain preliminary, yet detailed, insight into how university-based healthcare providers interact with patients. Interactions included providers initiating conversations with their patients about patients' sexual health and encouraging them to take actions to protect their health. Using RAA as a framework can be effective as it provides a specific framework to describe how providers are involved with patients and to make recommendations for interventions to improve practice. When designing interventions, it is important for public health professionals to consider the patient-provider interaction at multiple levels. That is, interventions

could address the intrapersonal level by encouraging providers to influence college students' attitudes and beliefs such that they feel more comfortable regarding their sexual health, the interpersonal level by improving the communication skills between provider and patient, and the organization and policy level by making structural changes within clinics or university to help healthcare providers initiate conversations about sexual health and recommend their patients to take preventive actions.

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